CABINET FOR HEALTH AND FAMILY SERVICES
Department for Public Health
Division of Adult and Child Health Improvement

911 KAR 2:130. Kentucky Early Intervention Program assessment and service planning.

RELATES TO: KRS 200.660(6), 200.664, 34 C.F.R. 303.322, 303.340-303.346, 20 U.S.C. 1471-1476

STATUTORY AUTHORITY: KRS 194A.030(7), 194A.050, 200.660(7), 34 C.F.R. 303.500, 20 U.S.C. 1476, EO 2004-726

NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health and Family Services and placed the Department for Public Health under the Cabinet for Health and Family Services. KRS 200.660 requires the cabinet to administer funds appropriated to implement the provisions of KRS 200.650 to 200.676, to enter into contracts with service providers, and to promulgate administrative regulations. This administrative regulation establishes the provisions of assessment and the Individualized Family Service Plans used in First Steps, Kentucky's Early Intervention Program.

Section 1. Assessment.

(1) Initial assessment activities for children without established risk conditions shall occur after the establishment of a child's eligibility for First Steps and prior to the initial IFSP in accordance with 911 KAR 2:120, Section 1.
  (a) An initial assessment shall occur within the areas of development that were determined to be below the normal range, a score greater than –1.0, as identified in the primary level evaluation.
  (b) The following shall complete an assessment:
    1. A discipline most appropriate to assess the area of documented delay and of which the family has the greatest concern; and
    2. The fewest additional disciplines as needed to assess the other areas identified as delayed.

(2) Assessment shall be the on-going procedure used by personnel meeting the qualifications established in 911 KAR 2:150 throughout the period of a child's eligibility for First Steps. An assessment shall reflect:
  (a) The child's unique strengths and needs;
  (b) The services appropriate to meet those needs;
  (c) The family's resources, priorities and concerns, which shall be:
    1. Voluntary on the part of the family;
    2. Family-directed; and
    3. Based on information provided by the family through personal interview; and
  (d) The supports and services necessary to enhance the family's capacity to meet the developmental needs of their child.

(3)(a) Assessments shall be ecologically valid and reflect appropriate multisource and multimeasures. One (1) source or one (1) measure shall not be used as the sole criterion for determining an intervention program. Assessment methods shall include direct assessment and at least one (1) of the following:
    1. Observations, which shall:
      a. Take place over several days if possible;
      b. Occur in natural settings;
      c. Include play and functional activities of the child’s day; and
      d. Be recorded in a factual manner;
    2. Interview and parent reports, which shall:
      a. Involve the use of open-ended questioning after the assessor establishes rapport;

b. Be provided by parents and other primary caregivers; and
c. Include the effect and impact of the child's disability on participation in natural environments; and

3. Behavioral checklist and inventories, which shall:
a. Be completed by caregivers by mail, phone or through face-to-face interview; and
b. Allow for comparison across settings.

(b) Direct assessment shall include one (1) or more instruments:
1. That are appropriate for an infant or toddler and that allows for adaptations for a disability as needed; and
2. That are criterion-referenced, which compares the child's level of development with skills listed in a chronological sequence of typical development.

(4) If after the initial assessments are completed, the IFSP team determines that a subsequent assessment is warranted, the following shall be documented on the IFSP:
(a) The parent has a documented concern that would necessitate another assessment;
(b) Why there is not a current provider on the IFSP team that can assess the area of concern; and
(c) What has changed in the child's ability or the family's capacity to address their child's developmental needs to warrant the subsequent assessment.

(5) A service coordinator shall obtain a physician's or ARNP's written consent in order to complete an assessment on a child deemed medically fragile. The consent shall be specific as to the skill areas that may be assessed.

(6) An assessment shall have a written report that shall include:
(a) A description of the assessment instruments used in accordance with subsection (3)(b) of this section;
(b) A description of the assessment activities and the information obtained, including information gathered from the family;
(c) Identifying information, including:
1. The central billing and information identification number;
2. The child's Social Security number, if available;
3. The name of the child;
4. The child's age at the date of the assessment;
5. The name of the service provider and discipline;
6. The date of the assessment;
7. The setting of the assessment;
8. The state of health of the child during the assessment;
9. The parent's assessment of the child's performance in comparison to abilities demonstrated by the child in more familiar circumstances;
10. The medical diagnosis if the child has an established risk condition;
11. The formal and informal instruments and assessment methods and activities used;
12. Who was present for the assessment; and
13. The signature of the assessor;
(d) A profile of the child's level of performance, in a narrative form which shall indicate:
1. Concerns and priorities;
2. Child's unique strengths, needs, and preferences;
3. Skills achieved since last report, if applicable;
4. Current and emerging skills, including skills performed independently and with assistance; and
5. Recommended direction of future service delivery;
(e) Suggestions for strategies, materials, settings, equipment or adaptations that shall support the child's development in natural environments; and

(f) Information that shall be helpful to the family and other providers in building on the team's focus for the child and family.

(7)(a)The initial assessment, other formal assessments and their resulting report shall be completed and sent to the service coordinator within ten (10) working days of the provider receiving the complete written assessment referral from the service coordinator. The complete assessment referral request shall include:

1. The point of entry's intake and child history documentation;
2. The primary level evaluation report;
3. The current IFSP; and
4. Authorizing CBIS billing forms.

(b) The provider who performed the assessment shall:

1. Verbally share the assessment report with the family and shall document the contact in the assessor's notes;
2. Provide the written report to the family and the service coordinator within the time frame established in paragraph (a) of this subsection; and
3. Write the report in family-appropriate language that the child's family can easily understand.

(c) If the time frame established in paragraph (a) of this subsection is not met due to illness of the child or a request by the parent, the assessor shall document the delay circumstances in his staff notes with supportive documentation made in the child's record by the service coordinator, and the report shall be provided to the service coordinator within five (5) calendar days of completing the assessment.

(8) Information gathered in the assessment shall be used to determine the service decisions included in the IFSP.

(9)(a) A child enrolled in First Steps shall receive an assessment as an integral part of service delivery.

(b) Assessment shall be ongoing in the First Steps Program to ensure concerns and strategies are focused to meet the child and family's current needs. An assessment provided as a general practice of a discipline, not due to the child or family's needs, shall be considered therapeutic intervention, not an assessment.

(c) Ongoing assessment shall ensure that the IFSP and services are flexible and accessible.

(10) Ten (10) calendar days prior to the earlier of the annual or six (6) month review of the IFSP or the expiration date of the IFSP, a service provider shall supply progress reports to the primary service coordinator and family.

Section 2. Individualized Family Service Plan (IFSP).

(1) The signed IFSP shall be a contract with the family and providers. A service included on the IFSP shall be provided unless the family chooses not to receive the service.

(2) The First Steps IFSP Form shall be used to record the IFSP. Items on the IFSP form shall be completed as instructed on the form. The accompanying initial IFSP documentation shall include:

(a) Appropriate evaluation reports in accordance with 911 KAR 2:120, Section 1 and assessments reports in accordance with this section;

(b) Identification of all covered services and early intervention approaches;

(c) Service delivery settings; and

(d) Signed approval by the IFSP team that shall include all individuals identified in the responsible party column of the IFSP including each parent or guardian present.

(3)(a) With the exception of a situation established in paragraphs (b) or (c) of this subsection, an authorized IFSP shall be valid for a period not to exceed six (6) months in length. An amendment that occurs to the IFSP shall be valid for the remaining period of the plan.

(b) If an IFSP is expected to expire within twenty-one (21) calendar days of a child turning age

three (3), an extension of the current IFSP shall be granted if the service coordinator provides the payment authorization coordinator at the Department for Public Health office with the following information:

1. A copy of the transition plan developed at the transition conference held at least ninety (90) calendar days prior to the child turning three (3);
2. A list of who attended the transition conference;
3. A copy of the IFSP that is expiring or has expired; and
4. A letter indicating that the:
   a. IFSP team agrees with the decision to extend the IFSP; and
   b. Parents are aware that they have the option of:
      (i) Having an IFSP team meeting; or
      (ii) Waiving their right to meet as an IFSP team.

(c) If an IFSP team meeting cannot be scheduled and convened prior to the current IFSP expiring, an extension may be authorized if the service coordinator provides the following information to the Department for Public Health office:

1. A letter requesting an extension of the current IFSP, including the dates the extension is to cover;
2. A detailed description of attempts made to hold an IFSP meeting and the reasons why the meeting cannot be held prior to the expiration of the current IFSP;
3. The scheduled date that the next IFSP meeting shall take place;
4. A copy of the current IFSP that has expired or is expiring, with amendments; and
5. Copies of the current progress reports from the IFSP team.

(d) If a family chooses not to receive a service included on the IFSP, for reasons such as illness or an inability to keep an appointment, the service provider shall document the circumstances in his staff notes.

(4) The following shall be adhered to in the development and implementation of the IFSP. IFSP team members shall:

(a) Provide a family-centered approach to early intervention;
(b) Honor the racial, ethnic, cultural, and socioeconomic diversity of families;
(c) Show respect for and acceptance of the diversity of family-centered early intervention;
(d) Allow families to choose the level and nature of early intervention's involvement in their lives;
(e) Facilitate and promote family and professional collaboration and partnerships, which are the keys to family-centered early intervention and to successful implementation of the IFSP process;
(f) Plan and implement the IFSP using a team approach;
(g) Reexamine their traditional roles and practices and develop new practices as appropriate that promote mutual respect and partnerships which may include a transdisciplinary approach;
(h) Ensure that First Steps services are flexible, accessible and responsive to family-identified needs; and
(i) Ensure that families have access and knowledge of services that shall:
   1. Be provided in as normal a fashion and environment as possible; and
   2. Promote the integration of the child and family within the community;
   3. Be embedded in the family’s normal routines and activities; and
   4. Be conducted in the family’s natural environment, if possible, and in a way that services promote integration into a community atmosphere which includes children without disabilities.

(5)(a) For a child who has been evaluated for the first time and determined eligible in accordance with 911 KAR 2:120, a meeting to develop the initial IFSP shall be conducted within forty-five (45) days after the point of entry receives the referral.

(b) If the initial IFSP meeting does not occur within forty-five (45) days due to illness of the child or approval to delay by the parent, the delay circumstances shall be documented on the IFSP.

(6) The IFSP shall be reviewed for a child and the child's family by convening a face-to-face meeting at least every six (6) months. An IFSP team meeting shall be convened more frequently if:

(a) The family or a team member requests a periodic IFSP review meeting;

(b) a therapeutic intervention service is added or increased.

(7)(a) The service coordinator shall obtain written approval or verified verbal approval from team members and shall document the means of obtaining that approval on the IFSP. The team members shall document the contact and approval in their staff notes. The contact and approval shall occur if:

1. A child is discharged from:
   a. A service due to achieving developmental milestones in that area; or
   b. The First Steps Program;
2. A service provider recommends a decrease in the frequency, intensity or duration of the service provided by that service provider;
3. The frequency of a service increases but not the number of units, such as changing from once a week for one (1) hour to twice a week for thirty (30) minutes;
4. A member of the IFSP team determines that an additional assessment is needed;
5. The family requests transportation services;
6. a. A service provider is being replaced;
   b. The replacement provider does not change the outcomes identified on the current IFSP; and
   c. The family agrees;
7. A team member changes provider numbers and the family wishes to retain that team member's services; or
8. An assistive technology device is ordered after an IFSP meeting was held at which the team members agreed that a specific assistive technology device was needed and strategies and activities were identified in the plan to meet the outcomes.

(b) The family shall be given prior written notice of any changes to the IFSP.

(8) With the approval of the family, the primary service coordinator shall arrange an IFSP conference to discuss the transition of the family from the program. The conference shall be conducted at least ninety (90) days and up to six (6) months before the child's third birthday and shall include:

(a) The family;

(b) A representative of the local education agency and representatives of other potential settings;

(c) The primary service coordinator as a representative of the First Steps Program;

(d) Others identified by the family; and

(e) Current service providers.

(9) The IFSP shall include:

(a) 1. A summary of the family rights handbook;
2. A signed statement of assurances by the family; and
3. A statement signed by the parent that complies with KRS 200.664(6);

(b) Information about the child's present level of developmental functioning. Information shall cover the following domains:

1. Physical development that includes fine and gross motor skills:
2. Cognitive development that include skills related to a child's mental development and includes basic sensorimotor skills, as well as preacademic skills;

3. Communication development that includes skills related to exchanging information or feelings, including receptive and expressive communication and communication with peers and adults;
4. Social and emotional development that includes skills related to the ability of infants and toddlers to successfully and appropriately select and carry out their interpersonal goals. These include:
   a. Attachment with caregivers or family members;
   b. Interactions with nondisabled peers and adults;
   c. Play skills; and
   d. Self-concept development;
5. Adaptive development that includes self-help skills and the ability of the child's sensory systems to integrate successfully for independent functions that include:
   a. Self-feeding;
   b. Toileting;
   c. Dressing and grooming; and
   d. Meaningful interaction with the environment;
6. Physical development that shall be documented annually and that shall include:
   a. Vision;
   b. Hearing;
   c. Health status; and
   d. If present, the established risk condition;

(c) Performance levels to determine strengths, which can be used when planning instructional strategies to teach skills;

(d) A description of:
1. Underlying factors that may affect the child's development; and
2. What motivates the child, as determined on the basis of observation in appropriate natural settings, during child interaction and through parent report;

(e) With concurrence of the family, a statement of the family's resources, priorities and concerns related to enhancing the development of the child;

(f) 1. A statement of the major outcomes expected to be achieved for the child and family, and the criteria, procedures, and time lines used to determine the degree to which progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes or services are necessary. Outcome and strategy statements shall:
   a. Be functionally stated;
   b. Be representative of the family's own priorities;
   c. Fit naturally into the family's routines or schedules;
   d. Reflect the use of the family's own resources and social support network; and
   e. Be flexible to meet the child and family's needs in expanded current and possible future environments; and

2. Strategy and activity statements that shall be practical suggestions that assist the family and other team members in achieving the family's desired outcome for the child and family.
   a. Typically strategies shall refer to the steps or methods a family and team will use to accomplish the outcomes;
   b. Activities shall refer to the routines or regular events that occur in the child's natural environment; and
   c. The strategies and activities area shall include how strategies will be embedded into activities, the criteria of how the outcomes shall be measured to determine mastery or progress and shall be developmentally appropriate, functional, valued by others, realistic and achievable and promote generalized use of skill;

(g)1. The specific First Step services necessary to meet the unique needs of the child and family to achieve the outcomes. Service documentation shall be stated in frequency, intensity, duration, location and method of delivering services, and shall include payment arrangements, if any;

2. A student in a field experience with an approved First Steps provider who provides therapeutic intervention shall complete and sign staff notes and the First Steps provider shall also complete and sign a staff note for each session in which the student facilitates intervention, including a statement in the note that direct one-on-one supervision was provided during the intervention session.

3. With the exception of group intervention, and unless prior authorization is granted in accordance with 911 KAR 2:200, Section 4, based on individual needs of the child, the frequency and intensity for therapeutic intervention for each child shall not exceed one (1) hour per discipline per day for the following disciplines:
   a. Audiologist;
   b. RN or LPN;
   c. Nutritionist or dietician;
   d. Occupational therapist or occupational therapist assistant;
   e. Orientation and mobility specialist;
   f. Physician;
   g. Physical therapist or physical therapist assistant;
   h. Psychologist, certified psychologist with autonomous functioning, psychological associate, family therapist, or licensed social worker;
   i. Speech language pathologist or speech language pathologist assistant;
   j. Teacher of the visually impaired;
   k. Teacher of the deaf and hard of hearing; or
   l. Developmental interventionist or developmental associate;

4.a. A description of the natural environment, which includes natural settings and service delivery systems, in which the early intervention service is to be provided;

b. How the skills shall be transferred to a caregiver so that the caregiver can incorporate the strategies and activities into the child’s natural environment; and

c. How the child’s services may be integrated into a setting in which other children without disabilities participate; and

5. If the service cannot be provided in a natural environment, the IFSP shall be documented with the reason;

(h) The projected dates for initiation of the services, and the anticipated duration of those services;

(i) Other services that the child needs, such as medical services or housing for the family, that are not early intervention services. The funding sources and providers to be used for those services or the steps that will be taken to secure those services through public or private resources shall be identified;

(j) The name of the primary service coordinator chosen to represent the child's or family's needs. The primary service coordinator shall be responsible for the implementation of the IFSP and coordination with other agencies and persons in accordance with 911 KAR 2:140, Section 1 (6);

(k) The steps to be taken to support the transition of the child to preschool services provided by the public educational agency, to the extent that those services are considered appropriate, or to other services that may be available, if appropriate.

1. With approval of the family, an IFSP transition conference shall occur at least ninety (90) days and up to six (6) months prior to the child's third birthday;

2. The IFSP transition conference shall involve:

a. IFSP team members;
b. Staff from the local public educational agency; and
c. Other agencies at the family's request that could be potential service agencies after the child turns three (3); and

3. The conference shall be held to review program options for the child at age three (3) and to write a plan, through the IFSP, for transition. The service coordinator shall chair this meeting; and

(l) Documentation substantiating the following if the child is being provided group intervention:
1. If the child is enrolled in day care or attending a group during normal routines, why the therapeutic intervention cannot be provided in the child's current group setting; and
2. Therapeutic intervention during group shall be directly related to the child's individualized strategies and activities as identified on the IFSP.

(10) If the IFSP team determines that a therapeutic intervention service shall be provided using a transdisciplinary team approach, the IFSP, provider notes and progress documentation shall include:
(a) Which disciplines are providing the therapy using this approach;
(b) Evidence of transdisciplinary planning and practice, including documentation of how role-release is occurring;
(c) How the skills are being transferred so that one (1) provider is capable of providing the services previously provided by the team;
(d) That the service is individualized to the particular family and child's needs; and
(e) If more than one (1) provider is present and providing therapeutic intervention services at the same time using a cotreatment approach:
1. Why this approach is being used;
2. The outcomes and activities;
3. Who is performing what activities; and
4. That the service providers involved are providing or learning about the therapeutic intervention at the same time.

(11) The family shall be encouraged to discuss their child's activities, strengths, likes and dislikes, exhibited at home.

(12) The IFSP shall highlight the child's abilities and strengths, rather than focusing just on the child's deficits.

(13) Every attempt shall be made to explain the child assessment process by using language the family uses and understands.

(14) The family may agree, disagree, or refute the assessment information.

(15) The family's interpretation and perception of the assessment results shall be ascertained and the family's wishes and desires shall be documented as appropriate.

(16) If an agency or professional not participating on the IFSP team but active in the child's life makes a recommendation for an early intervention service, it shall not be provided as a First Steps service unless the IFSP team considers the recommendation, verifies that it relates to a chosen outcome, and agrees to it.

Section 3. Incorporation by Reference.

(1) The First Steps Individualized Family Service Plan (IFSP), January 2005, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Public Health, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (23 Ky.R. 3136; Am. 3854; 4172; eff. 6-16-97; 25 Ky.R. 664; 1410; eff. 1-19-99; Recodified from 908 KAR 2:130, 10-25-2001; 29 KyR. 2790; 30 Ky.R. 325; 625; 888; eff. 8-20-03; 31 Ky.R. 492; 1276; eff. 1-19-05).